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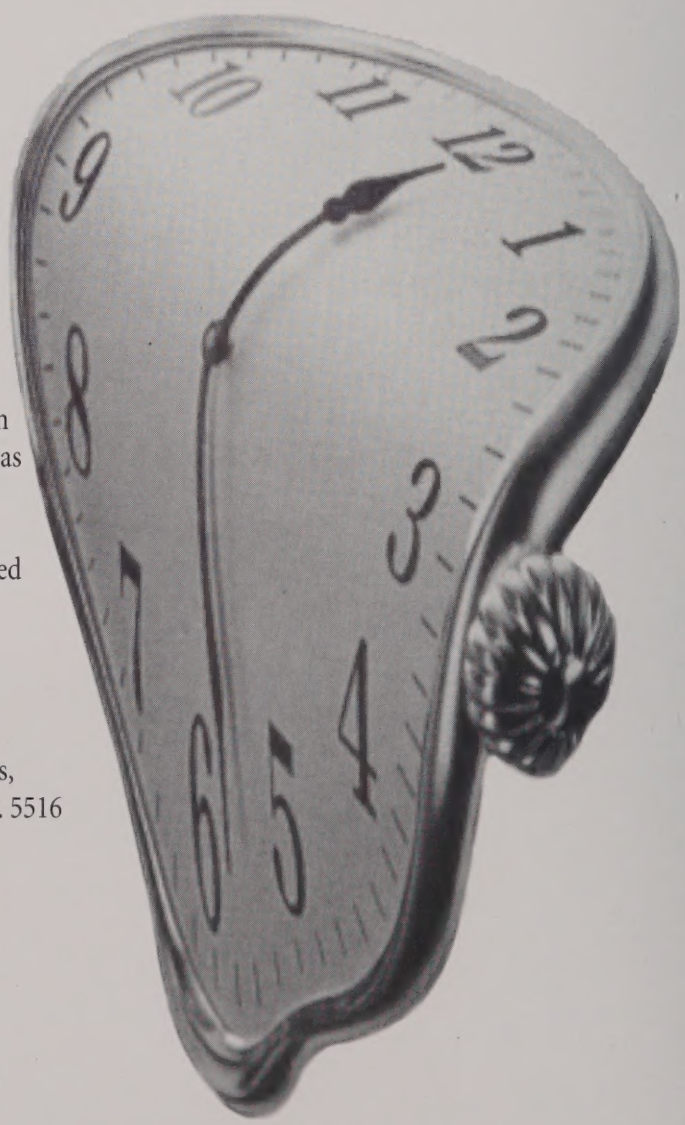

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THE
Hampden Hippocrat
SPRING 1997

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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HAMPDEN DISTRICT MEDICAL SOCIETY 1996-1997 SEASON

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PLACE: **THE COLONY CLUB**
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SOCIAL HOUR: 7:00 p.m.

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From The Editor

"Controversial" best describes the reception to last year's Medical-Legal Dinner, especially among the lawyers who were present. Thanks to a tape recording of the proceedings and a promise from Dr. Glackin in the last "Hippocrat," readers are treated to a blow-by-blow (no pun intended) report and interpretation by yours truly, but are also advised to read the advice proffered by attorneys Anita F. Sarro and Kelly A. McCarthy, and Pamela Berger, Director, Corporate Risk Management of Baystate Health Systems.

After a year away since his last edition, this editor has the opportunity to check projections then made against events unfolded. Unfortunately, things are getting as bad as had been expected. Money and power are more and more concentrated in fewer and fewer managed care organizations despite recent attempts to reign in some of their autocracy. If one sells off a part of its operation, it is to another investor owned entity. How many non-profit hospitals have been built vs. for-profit? Will we ever again see a new American hospital conceived in charity and dedicated to the proposition that all citizens are medically equal? Perhaps the anonymous "Medical Maranos" reflects physicians' need to hunker down and fantasize until the upcoming Dark Ages pass.

Dennis S. Gordan, M.D.
Editor

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CONTRACT REVIEW

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Attorney Marie Angelides
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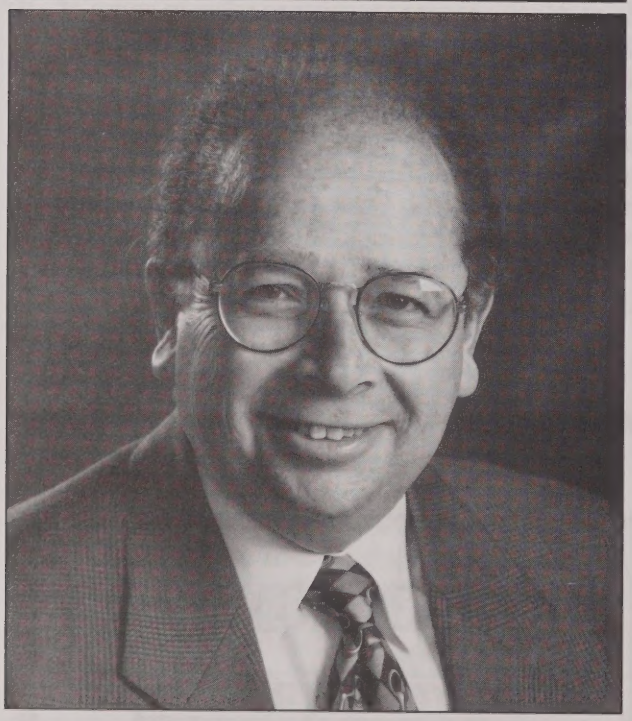
The Art of Medicine

In the early 1900's, Harvey Cushing noted, "A physician is obligated to consider more than a diseased organ, more even than the whole man. He must," he said, "view the man in his world."



Daniel Dress, M.D., President

The bridge toward this noble goal is through our study and appreciation of the humanities and the arts.

Humanities have been called that "broad field of discourse that looks at culture, life, and our intellectual heritage." They are a branch of learning, concerned with human thought and relations, and should be distinguished from science, in that the latter focuses on what is testable and provable, whereas the humanities look to the unmeasurable, and help prepare doctors to better understand their patients.

Modern scientific training has led doctors to believe that every question has an answer, which can be found if we only look carefully enough. Study of the humanities, however, teaches physicians that this belief is not always true, encouraging us to look beyond the disease itself, and to explore other aspects of illness. In this process, we can learn more about life, the joy and suffering of this world, and about the travails of being a patient – or a doctor. As new ethical questions arise, the humanities, which are the record of how men and women have looked at quandaries in the past, can help physicians to enlarge their judgments.

It is because of the increasing belief in this concept, that, currently, one-third of U.S. medical schools have some sort of literature program. At Dartmouth Medical School, which offers "Literature and Medicine," Dean Joseph O'Donnell has said, "(the course) teaches students to listen to patients' 'stories,' which are about symptoms and signs, but also about their lives. We have the privilege to listen to people's stories. That, I think, is an essential part of being a doctor."

The world of opera also, can bestow upon physicians greater insight into the problems of humanity and of our own lives. Consider the third act of "La Boheme." Here we have a visualization in dramatic, yet realistic, terms of the impact disease in one person has on the remainder of the

family. Rudolfo, frightened by the illness of his beloved Mimi, acts out his fear in a manner that sends her a message that he no longer loves her. Confused, Mimi decides to leave him, although the two are still very much in love. Such are the plots of opera, but also, such are the scenarios of life. What physician has not had to deal with the distraught family member, when the focus should be on the patient with the illness?

Why do we physicians need the humanities and the arts to show us the effect of disease on a family, since we already see these problems daily? The answer is simple: to confront us with these human emotions in a setting where we can contemplate them, and experience a reaction to them. And as we confront these problems in our recreational pursuits, whether that be through opera, or literature, or other activities, we have the opportunity to think about the issues, and to respond without the pressures of the work day. We can then, in the repose of the evening, contemplate our view of life, of human suffering, and our own response to the issues and to our patients. ■

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Winter Meeting Features AMA and MMS Plans

by Dennis S. Gordan, M.D.

The winter meeting of the Hampden District Medical Society at Springfield's Sheraton Hotel featured the traditional address by the President-Elect of the A.M.A. as well as a presentation of the plans for facility expansion for the Massachusetts Medical Society.

The featured speaker, Percy Wootton, M.D., a cardiologist from Virginia, reviewed the A.M.A.'s accomplishments in Washington and the states over the past year as well as its plans for 1997. He noted that success was likely to continue if medicine worked with both major parties over a timeframe of years.

The featured speaker, Percy Wootton, M.D. reviewed the A.M.A.'s accomplishments in Washington and the states over the past year as well as its plans for 1997.

Nineteen-ninety-six saw the passage of the Kennedy-Kassebaum health reform bill, which should eventually remove 25,000,000 from the category of uninsured. Antitrust relief was partially realized, and efforts at further gains will continue this year. Proposals that would have sent M.D.'s to jail by criminalizing errors in coding were eliminated. Minimal standards for lengths of hospital stays after childbirth were accepted. Insurance for mental illness on a par with that for physical disease was mandated. Regulations barring gag rules were adopted by 16 states, and there are plans to bring this to the national level this year. (The President has already said that he will sign this if Congress passes it.) The F.D.A. has promulgated regulations restricting children's access to tobacco.

Three major areas of A.M.A. activity now are Medicare reform, opposition to physician assisted suicide, relief of pain at end-of-life care, and the American Medical Accreditation Program.

Dr. Wootton said Medicare had grown from a $5 billion dollar program in its first year, to $180 billion dollars last year, and a likely $360 billion dollars in 5 years. He warned against the administration's stated intentions to apply the band aids of cuts in provider fees, which would only delay what appears to be Medicare's inevitable insolvency by about 10 years, and instead advocated major reworking. The A.M.A.'s long-term solution includes several points, namely: 1) protect patient choice by making a defined contribution to insurance; 2) modernize Medicare and neutralize the need for Medigap insurance, since Medigap insulates patients from making any cost / benefit decisions; 3) meet the needs of the Baby Boomers by a long-term shift to private savings via Medical Savings Accounts; 4) shore up the hospital trust fund (which is heading for insolvency in 2001 or 2002); and 5) limit the size of cuts to physicians since, at least in most areas, this would lead to problems in access. Apparently even the New York Times felt that the A.M.A. proposal was likely to restore the confidence of the elderly.

In June, the Supreme Court is likely to rule on two cases pertaining to physician-assisted suicide. The A.M.A. remains opposed to such suicide facilitation simply because, as Dr. Wootton indicated, a physician would never want a patient to think that his doctor would do anyone in. Related to this, the A.M.A. instead is working to improve pain relief by physicians engaged in end-of-life care. Patients and physicians need to know the options for relief better and become more familiar with hospice care.

continued on next page

District Meeting

continued from page 7

The House of Delegates has developed an American Medical Accreditation Program that will be piloted in Massachusetts. Dr. Heyman, M.M.S. President, is on the governing board. The plans are to work with state and local medical accreditation programs that are or will be developed, as well as with specialty societies, and reclaim this process as a professional activity rather than one done by government or proprietary groups. Once a practice has been successfully evaluated, it will have the A.M.A.'s "gold seal." The program will look at the areas of practice quality (with the appropriate specialty groups), ethics, record-keeping standards, and credentialing (with state and local medical societies.) This should relieve offices of the burden of multiple inspections.

Dr. Wootton, President-Elect of AMA and
Dr. Dress, President of HDMS at the District Meeting

Prior to dinner, Dr. Charles Welch, Chairman of the M.M.S. Committee on Buildings, presented the rationale for the Society to seek larger facilities. Major points were that the growth area for the society was, programmatically and financially, through publications, both print and electronic, and education; our present facilities limited. growth; and that the M.M.S. is in a relatively better financial situation than it was at the time it purchased its present building – i.e., in 1982 the society invested 53% of its worth in the $5.3 million facility it now owns, and now expects to invest only 44% to procure a $30 million building of about 200,000 sq. ft. It would likely be within 10 minutes of the present Waltham headquarters. ■

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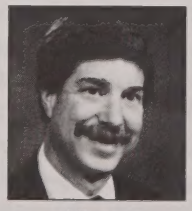

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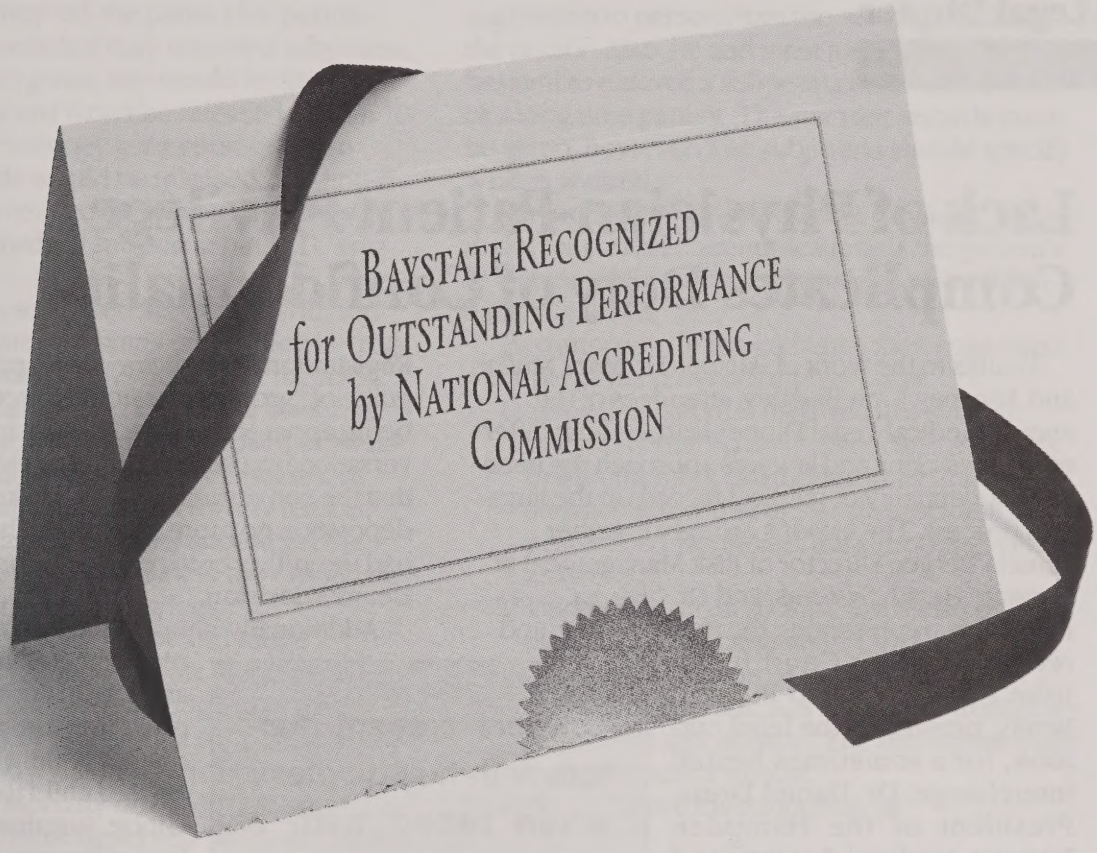

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For this reason, we are proud to announce that Baystate Medical Center, Franklin Medical Center and Mary Lane Hospital have been awarded with full three year accreditation from the Joint Commission on Accreditation of Healthcare Organizations. Each hospital was required to meet standards addressing everything from patient care to organizational ethics, from providing a continuum of care to continuous quality improvement efforts.

In addition, Baystate Medical Center has been awarded "Accreditation with Commendation" representing the highest level of achievement awarded by the Joint Commission and attained by only a small percentage of hospitals throughout the United States.

Our rating is a reflection of our ongoing commitment to deliver high quality patient care to the members of the Western New England community. We view this recognition as testimony to our dedicated team of Baystate Health Systems' health care professionals.

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Lack of Physician-Patient Privilege Complicates Duty of Confidentiality

Thanks to the work of liaisons Dr. Mark Mullan and Attorney John Baggley, attendees of the annual Medical-Legal Dinner learned how differently physicians and lawyers approach the issue of confidentiality of medical records in the litigation process. The liaisons brought together Pamela Berger, Director of Risk Management at Baystate Health Systems, and Dr. Claudia Kopelman, representing the medical view, and retired Superior Court Judge John F. Moriarty and Richard Brody, presenting the legal outlook, for a sometimes heated interchange. Dr. Daniel Dress, President of the Hampden District Medical Society and Attorney John Rooney, President of the Hampden County Bar Association, introduced the medical and legal speakers, respectively.

Lawyers present doctors with helpful ploys when faced with a subpoena

Although physicians have traditionally understood that trust, based on the patient's belief that information given to the physician would not be divulged to others, was central to their ethic, the law in Massachusetts was silent on this issue until 1984. At that time, as discussed by Judge Moriarty, the Massachusetts Supreme Judicial Court, in response to a question from the Circuit Court of Appeals for the First Circuit regarding what was the law in Massachusetts, indicated that although confidentiality was a general patient right, there might be circumstances where disclosure would have to be made. Nevertheless, in 1985, the SJC found that a doctor could be liable for damages for violation of confidentiality, as could whoever pushed the doctor into disclosure. It appears that the doctor may be liable for the damages caused by disclosure (e.g. damages such as a decreased award to a plaintiff because plaintiff's doctor gave defense attorney information about the plaintiff that helped the defense), but the doctor need not pay punitive damages, since, as in libel suits, only compensatory damages may be awarded. Regardless of these judicial precedents, the Board of Registration in Medicine found one physician guilty of "gross professional misconduct" after being apparently duped into an improper conversation by a defense attorney who indicated that the conversation would make the next day's deposition go more smoothly. The SJC somehow had the authority to remove "gross" from the Board's decision.

Additionally, although child abuse must be reported, a Cambridge psychiatrist, who showed a report regarding the mother (who was not her patient) of a possibly abused child to the Boston Globe, sustained a $10,000 fine, loss of license, and a requirement to perform 100 hours of community service.

In presenting the defense lawyer's view, Attorney Brody maintained that the plaintiff has put his or her prior physical and mental condition into controversy. In order to prove that a harm was done, the plaintiff has to prove that the physical or mental status is worse as a result of the injury. The defense must have access to the information (i.e. the medical record) that could prove that no real damages occurred. The doctor is thus obliged to give the information to the defense (as well as the patient or plaintiff's attorney). Mr. Brody further elaborated that the request for records is an accommodation since it can free the physician from a personal appearance for a deposition. He also pointed out that a part of a record or a report (with a bill to cover its cost) instead of the record, or a demand that the patient's bill be paid before the records are released, are illegal or unacceptable. Even mental health portions must be sent if the claim is about psychological damage. It was later pointed out that there are sensitive portions of a chart (re: HIV, psychiatry, drug abuse, etc.) that need a special court order.

Apparently, Ms. Berger felt that there was a difference between a subpoena and a court order, and on that basis she recommends to Baystate

Continued on next page

physicians that they call the patient for permission to release records if they receive a subpoena. If permission isn't given, she would let the attorney know the record won't be released, within 10 days, and let the attorney get a court order, to which the records would be released. She noted that hospitals have specific protection from suit for releasing records to subpoena but M.D.'s do not.

Dr. Kopelman seconded Ms. Berger with the claim that there are two kinds of subpoenas - regular and court ordered. She noted that the AMA indicates physicians must respect the laws, but objected to the heavy handed approach of a subpoena. She felt most patients are unaware that their records could be released for any reason. She felt the requesting attorney should get the patient's permission and send it to the physician with the appropriate copying fees.

At this point Attorney Brody and Judge Moriarty basically agreed that Ms. Berger and Dr. Kopelman were under the wrong impression. That is, there is only one kind of subpoena, and if it is ignored, the lawyer may go to court to have it enforced. Judge Moriarty qualified that a subpoena, to be proper, must be served "in hand," meaning person to person from the serving official to the doctor. Also, he and most judges would be hesitant to enforce a subpoena for all the records of a long time patient. The relevant records must be given, however. The subpoena should specify what is wanted.

Mr. Brody pointed out that the privilege, if any, in doctor patient communications is the patient's to waive, and in suing, the privilege of confidentiality is waived.

Two attorneys in the audience then suggested a couple of maneuvers for physicians:

1) Since the patient is involved in a suit (as plaintiff certainly, or as defendant, probably or imminently), call that attorney and let the attorney know that unless the doctor gets the protection of a release, the subpoena will be answered.
2) Under Rule 45 on subpoenas, file an objection to the subpoena within 10 days. Some attorneys have simple forms to file this objection. This releases the doctor from possible contempt of court. The ball is now back in the requestor's court.
3) Never ignore the subpoena. ■

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Physicians: What To Do When You Receive A Subpoena

This summary was prepared by Anita F. Sarro and Kelly A. McCarthy, attorneys practicing health law at Bulkley, Richardson and Gelinas, LLP in Springfield, and Pamela Berger, Director, Corporate Risk Management of Baystate Health Systems.

Introduction. An official-looking document comes into your office. It looks like it's been issued by an attorney's office or court. It says that you must appear at a certain time and place to provide documents or information about a patient. You have received a subpoena. It requires you to release confidential patient information. What do you do?

Physicians should obtain specific patient authorization or a court order prior to releasing documents or testimony in response to a subpoena

There are many types of subpoenas. Some require an appearance at a trial, others demand an appearance at a grand jury proceeding or a deposition. Some are issued in connection with criminal actions, other with civil actions. Some require production of certain documents (a subpoena "duces tecum"), others require the physician to appear personally. Because the situations can vary so much, it is difficult to come up with an approach that will apply to all subpoenas in all cases. But all of them have one thing in common: they cannot be ignored.

The first thing to do when you receive a subpoena is to read it carefully. Look for the following information:

a) what is the return date? (that is, on what date are you being required to produce documents or to appear personally in court or at a deposition?);

b) what is the court? (the federal court or a state court such as the District Court, Superior Court, Juvenile Court or Probate Court, etc.);

c) what is the action or proceeding? (a criminal trial, a civil trial, a grand jury proceeding or a deposition, etc.);

d) who are the parties to the action and who issued the subpoena? (In many, but not all, proceedings the parties will be identified in the caption of the subpoena.);

e) has the person whose confidential information the subpoena is demanding that you disclose (your patient) received notice (a copy) of the subpoena? (Is your patient a party to the action?; if so, then the patient's attorney also should have received notice of the subpoena, and sometimes the subpoena will reflect that notice has been given to the patient's attorney.)

f). what is the scope of the request? This is important. Review carefully the documents or information that the subpoena requests. (For example, is the subpoena seeking just medical records? the records of one patient or several? other documents such as correspondence or bills concerning a patient? for a specific time period or all records?)

An Example. You receive a subpoena to produce medical records at a deposition on a certain date in the civil action of Jones v. Smith in state Superior Court, where Mr. Jones' attorney requests the patient records of Mr. Smith. You are an internist who has treated Mr. Smith for a broken leg.

Physicians have a duty to maintain the confidentiality of patient information and may be held liable if they breach that duty. In Massachusetts, there is a statute, (General Law Chapter 111, Section 70), that specifically authorizes hospitals and clinics licensed by the Massachusetts Department of Public Health to disclose patient

information in response to a subpoena (only where the patient is the party identified in the caption of the subpoena) without violating the duty to keep confidential patient information. Physicians, however, are not covered by this DPH statute.

Therefore, in responding to a subpoena, a physician should follow this "General Rule": A physician should release patient information only with specific patient authorization or a court order.

A subpoena generally is not issued by a judge or considered a court order. If you ignore it, however, the requesting party can go to court and ask the court to enforce it or even to impose sanctions. So, again: Do not ignore a subpoena. There simply are too many variables to outline an approach to responding to a subpoena that will be appropriate in all cases. However, the following steps are consistent with the "General Rule" above:

1. If it is appropriate, write to, telephone or meet with the patient and obtain patient authorization. It is preferable to obtain the patient's authorization in writing; you may choose to enclose an authorization form with any written notice you send to the patient. If you obtain verbal authorization from the patient to release the information requested in the subpoena, document the patient authorization prior to any release of information.

2. If the patient is not contacted or refuses to authorize the release of such information:
   a) if time permits, write to the requesting party that you will not release the information without patient authorization or court order and send the patient a "cc" copy of the letter;
   b) if time is short, call the requesting party and convey the same information over the phone.

3. Often, it will be possible to resolve matters in a mutually acceptable manner. If it is not possible, then you (or your office personnel, if the subpoena requests the "Keeper of the Records") must appear at the place and time designated in the subpoena. At that time, you can enter your objection on the record. In contested cases, a physician also may choose to seek advice of legal counsel. (For example, Massachusetts Rule of Civil Procedure 45(d) governs the manner in which a person may serve a written objection to a deposition subpoena. However, not all subpoenas are deposition subpoenas; furthermore, filing a Rule 45 objection does not automatically excuse a person from the obligation to appear at the place and time designated in the subpoena.)

4. Some types of situations require special attention and may require a different approach. These include:
   a) Where the subpoena requests the disclosure of sensitive information. Types of sensitive information protected by statute include alcohol or drug treatment records, HIV testing information, psychiatric or mental health treatment information or communications with psychotherapists, social workers or domestic violence or sexual abuse coun selors. Specific written patient authorization or specific language in a court order must be obtained prior to releasing such sensitive information.
   b) Where the subpoena requests the testimony of the physician at the court proceeding or deposition, then personal presence of the physician is required. The physician still should obtain patient authorization or court order prior to testifying.
   c) Where the patient objects to the physician's production of records or testimony in response to the subpoena. In such cases, the physician is on notice of the patient's objections and desire to keep such informa tion confidential; the physician should not disclose patient information until a court order has been obtained.

5. Finally, the patient authorization or court order should specifically authorize or order the release of the information requested in the subpoena. If you receive the proper patient authorization or court order, read the document request very carefully and provide only the documentation sought. For example, if the subpoena requests "medical records of treatment rendered on January 5, 1995," produce only those medical records and none other.

In sum, physicians have a duty to keep confidential patient information. Physicians also have an obligation to respond, and not to ignore, a subpoena. Unless and until Massachusetts law is amended to afford physicians statutory protection concerning disclosures of confidential patient information in response to a subpoena, physicians should obtain specific patient authorization or a court order prior to releasing documents or testimony in response to a subpoena. ■

1996 Interim Meeting Of The House of Delegates

by Alan M. Harvey, M.D.

Introduction

- The AMA House of Delegates met in Atlanta, December 8-11, 1996
- At the Opening Session there were 426 delegates seated representing every state and territory and also virtually every national specialty society.
- Dr. Clarence (Clancy) Holland, Virginia Beach, Virginia, received the Dr. Benjamin Rush Award for his public service in the Virginia State Senate.
- The Minnesota Medical Association received the President's Citation for Service to the Public for its "Violence in the Media" campaign.

Governance

The House adopted recommendations in a report of a Special Committee that provides for **four year terms** with a **maximum tenure of eight years**. This is a change from the previous provisions of three three-year terms for a maximum tenure of nine years.

At the same time the House rejected proposals of the Special Committee that would expand the size of the Board by providing "slotted seats" to specified specialty categories and large group practices.

The House also voted to establish a new Section for International Medical Graduates. The Reference Committee noted the contributions of IMG's to medicine and the strong need and desire for a Section from those present who pointed to the Section as an appropriate response to a growing segment of the physicians population with special concerns. The committee also noted that there was potential for AMA membership growth among IMG"s.

American Medical Accreditation Program (AMAP)

The House considered a Board report and three resolutions on the implementation of AMA's new program for setting standards for practicing physicians, called the American Medical Accreditation Program (AMAP). This program was developed in response to previous House actions calling on the AMA to ". . . support development of standardized criteria to be used in managed care contracts for reviewing physicians' office and medical records in order to avoid multiple review."

The Board detailed the extensive outreach conducted with the Federation since the 1996 Annual Meeting and believes the response from the Federation also reflects the spirit of professional unity demonstrated in the action calling for promoting trust and cooperation throughout the Federation.

The Reference Committee reported that it heard testimony stressing the need to consolidate credentialing and physician office site review and supporting the AMAP program as a mechanism through which the Federation can work together to achieve this result.

The Reference Committee was assured that AMAP will employ the Federation concept and network with state and county medical societies' and specialty societies' existing credential verification services and with commercial vendors who collaborate with Federation organizations.

The Reference Committee also reported that it heard testimony stressing the need to proceed without delay because of the pressing need of physicians for a consolidated effort in credentialing and physician office site review. Commercial vendors, HMO groups and others are beginning to or will soon develop their own verification programs. These efforts often proceed with little physician input.

The House approved as amended the recommendations in the Board report as follows:

1. That the AMA continue implementation of the

American Medical Accreditation Program.

2. That periodic progress reports be disseminated to the Federation, and that the House of Delegates receive a progress report at each Annual and Interim Meeting.
3. That as AMAP implementation proceeds, the Board of Trustees continue to include Federation (county, state, and specialty medical societies) and related organizations in every phase, including: appointment to the Governing Body; defining roles for each Federation component on the Advisory Committees; and the formation of partnerships with appropriate Federation organizations in each of the five components of AMAP.

Counseling and Testing of Pregnant Women For HIV

After much debate in the Reference Committee and on the floor of the House of Delegates, the House voted to reaffirm existing policy on counseling and testing of pregnant women for HIV. The policy states:

> The AMA supports the position that there should be mandatory HIV testing of all pregnant women and newborns with counseling and recommendations for appropriate treatment.

In a related action the House adopted a substitute resolution that states:

> That physicians and other health care providers who are principally responsible for the prenatal care and delivery have a mandatory responsibility to provide information and counseling to pregnant women about the risk of vertical transmission of HIV and the benefits of treatment and a responsibility to document such counseling, testing and treatment results.

Termination of Late Term Pregnancies

The Reference Committee reported that it heard extensive and passionate testimony on two resolutions opposing the termination of late term pregnancies. The committee noted that this issue is also related to the importance of the physician-patient relationship and the belief that governmental interference into the practice of medicine is inappropriate and ultimately harmful to the patient.

The committee proposed a substitute resolution, believing that it is important for the Association to assist in providing the scientific and clinical expertise to establish exactly what standards of good medical practice demands of physicians. The committee believed that the political and judicial decisions that society must make should be based on good science and good medicine.

After much debate the House adopted the following substitute resolution:

> That the AMA Board of Trustees, in consultation with pertinent AMA Councils and medical specialty societies, undertake a study of which late term pregnancy termination techniques and circumstances conform to the "standards of good medical practice" as required by current policy, and
>
> That the AMA will work with pertinent medical specialty organizations to develop appropriate clinical practice guidelines for late term pregnancy termination.

Funding of Graduate Medical Education

The Council on Medical Education provided a comprehensive study of the options for financing graduate medical education. This report is in response to a growing perception that the US is training through graduate medical education (GME) a number of physicians that is beyond national requirements and that the excess is not to the national benefit.

This is coupled with the need to reduce the number of GME positions funded by Medicare and to restructure Medicare to a sounder fiscal basis. Although the Federal Government is the major financial supporter of GME, it has little control over the numbers or the distribution of GME opportunities other than through financial support.

The Council offered eight recommendations that were adopted as amended:

1. That the AMA affirm and support current policy for a Federal system of financing Graduate Medical Education based on an all payer contribution.
2. That the AMA affirm and support current policy for a Federally authorized public/private sector planning initiative to monitor, guide and distribute the funding from the all payer fund consistent with the need to improve Medicare fiscal solvency and to respond to regional and specialty needs.
3. That the AMA support the establishment of an authorization system yet to be specified (for example, a voucher system) to provide funding for the training program at the site where training occurs.

Continued on next page

1996 Interim Meeting

Continued from page 15

4. That the AMA support the development of a portable authorization system for use by the US medical graduates, recognizing that the MD/DO degree is only a mid-point of formal medical education.
5. That the AMA support establishment of an authorization system which guarantees funding for US Medical Graduates and additional funding for International Medical Graduates on a competitive basis, based on limits set by the new public/private sector workforce planning group.
6. That the AMA support the development of alternative options for support of teaching hospitals to achieve fiscal stability with reductions in Medicare Indirect Medical Education Adjustment payments and to develop alternative approaches to provide patient services previously provided by resident physicians.
7. That the AMA encourage the use of international assistance funds to provide for appropriate US training for physicians from other countries to increase the level of medical care they would provide in their home countries.
8. That the AMA support efforts to allow completion of training of international medical graduates already in training who might be adversely affected by an authorization system.

Physician Workforce Development – Open Hearing

At the Interim Meeting the AMA served as host for a distinguished group of professional organizations to hold an open hearing on the issue of physician workforce. About 1000 physicians attending this historic meeting. Sponsors included the American Association of Colleges of Osteopathic Medicine, the American Osteopathic Association, the Association of Academic Health Centers, the Association of American Medical Colleges, the Institute of Medicine, the National Medical Association and the American Medical Association.

The objective of this hearing was to provide an opportunity to hear testimony from all interested parties, develop a consensus statement to reflect the common themes of agreement, and then provide the Federal Government the very best advice on this issue. In addition to the oral testimony, many organizations submitted written statements. Dr. Richard F. Corlin, Speaker of the House of Delegates, presided.

Health System Reform

The House considered a report from the Council on Medical Service on employment-based health insurance plus a resolution sponsored by 13 state delegations entitled, "Individually Selected and Owned Health Insurance System Transformation".

The House amended the recommendations in the report calling on the AMA:

1. To place a high priority on implementation of current policy which supports equalizing the tax exemption of individually purchased health benefits with that of employer-based health benefits.
2. To continue to place a high priority on enactment of federal legislation to expand opportunities for employees and others to individually own health insurance through vehicles such as medical savings accounts.

The House also adopted a substitute resolution that changed current AMA policy on this issue to read as follows:

1. Affirm its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services.
2. Actively support the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complimentary position, into the Association's position on achieving universal coverage and access to health care services. To do this the AMA will:
   a. Support legislation that would provide the employer with the same tax treatment for payment of health insurance premiums whether the employer provides the health insurance plan for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance.
   b. Support the concept that tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly.
   c. Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of

the group to continue their employer sponsored group coverage.

d. Work toward establishment of safeguards, such as a health care voucher system, to ensure that contributions made to the employee for the purchase of individually selected and individually owned health insurance are used for that purpose.

e. To ensure that the health insurance plan purchased by the individual employee is sufficient to provide a basic level of health care and does not increase the probability that the employee will become uninsured, the AMA would work toward the establishment of the following guidelines: 1) minimum benefit requirements, including catastrophic protection, 2) fiscal solvency of the plan, 3) provision of basic consumer information, 4) protection of the consumer from fraud, 5) guaranteed issue, 6) guaranteed renewability, and 7) rate reform.

The House also revised the policy to call on the AMA to support individually selected and individually owned health insurance as the preferred method for people to obtain health insurance coverage.

Conclusion

Time prevents me from commenting on everything that was considered by the House of Delegates.

Meetings of the AMA House of Delegates are open to every member and are conducted in a most democratic manner. They provide those who attend a unique educational experience as a wealth of information is disseminated and discussed. Members may present testimony at the Reference Committee hearings and there are many other opportunities to get your views across.

If you cannot come to the meetings, let your delegation know your opinions and concerns.

Many AMA policies and programs began with an individual physician who had a good idea and coaxed it through the democratic process.

I will be happy to respond to any questions. ■

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Here's Our Agenda

It's simple. It's straightforward. And it represents the future of medicine. The American Medical Association presented to the Republican and Democratic leadership this agenda for the upcoming 105th Congress. Your AMA membership strengthens our voice in support of physicians and their patients. . . and will enhance our efforts to turn these goals into reality.

- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.
- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.
- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.
- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.
- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

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Medical Maranos

Anonymous

Come with me now into the bowels of the hospital, to the subbasement area known only to the maintenance staff, but no longer visited by them. There has been no need for anyone to come down here since pathology stopped incinerating its own specimens – at least, not until lately. So don't worry about the dust and the cobwebs, because as you can see, there is light under the door at the end of this tunnel.

Even at 50 feet, you can start to hear voices, but when I knock they are replaced by silence. The door opens a crack and I pronounce the "Just say no to M.C.O." passwords. With that we are let in to witness what you thought was a lost way of life: Doctors, many of whom you know contract with managed care organizations, are engaged in an intense discussion. The talk, however, is not about lengths of stay, costs per month per member, gatekeeping, or any of the other life-sapping topics so dear to the management heart. Rather, it is about medical management of difficult cases.

What's going on, you ask? Well, these are the members of a secret society called the Medical Maranos. They took the name when they realized the parallels between American doctors of today and certain Spanish Jews who lived during the Inquisition. Faced with the choice of conversion or death, these Maranos nominally converted, but kept to their old religion in secret,hoping that at some point they would be freed from the tyranny of their situation. (The New York Times did a recent story indicating that some of these people's descendants have only lately become known.) Similarly, these doctors have been faced with the choice of accepting an imposed system or losing their livelihoods. They went through a conversion process, were "educated" about the new doctrines of managed care, seemingly renounced their previously-held value system (i.e., the patient comes first), and adopted the new catechism (the medical cost ratio must be minimized). Like the original Maranos, they are hoping that "this, too, will pass," and their descendants, at least, will once again be open and unabashed patient care advocates. They know, however, that unless they continue to practice at least the intellectual aspects of their profession, that there may well be no one to pass the medical ethic on to future generations. The ultimate cunning of the architects of managed care may not be that they have distanced themselves from the costs of medical education so much as that they have seduced so many medical educators away from "orthodox" medical ethics, and this is something the Medical Maranos have determined to fight, even if only in secret. Every week, therefore, they gather here to discuss what they would ideally do for patients, if the payor system allowed; to commiserate over their loss of autonomy; and to derive what comfort they can from knowing that although night has descended on the medical profession, their light, like the Maranos' secret faith, is still burning. ■

Like the original Maranos, they are hoping that "this, too, will pass"

New Members Welcome

Chester Andrzejewski, Jr., M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: March 20, 1953
Medical: Tufts University School of Medicine 1984
Internship: Hospital of the University of Pennsylvania 1984-1985
Residency: Hospital of the University of Pennsylvania 1985-1987
Specialty: Transfusion Medicine/Clinical Pathology

Paul C. Bettinger, M.D.
3455 Main Street
Springfield, MA 01107

Born: May 8, 1963
Medical: Tufts University School of Medicine 1985-1989
Internship: Bellevue Hospital/NYU Medical Center, New York 1989-1990
Residency: Bellevue Hospital/NYU Medical Center 1990-1994
Fellowship: Mayo Clinic, Rochester, MN 1994-1995 (Hand Surgery) Mayo Clinic July 1995-December 1995 (Research Fellow)
Specialty: Hand Surgery

Albert J. Cennerazzo, M.D.
Valley Medical Associates
125 Liberty Street
Springfield, MA 01103

Born: July 21, 1952
Medical: University of Massachusetts Medical School 1992
Internship: Baystate Medical Center 1992-1993
Residency: Baystate Medical Center 1993-1996
Specialty: Internal Medicine/Pediatrics

Gregory G. DeCandia, M.D.
Medical Care of West Springfield
1132 Westfield Street
West Springfield, MA 01089

Born: December 5, 1958
Medical: University of Vermont Medical College 1986
Internship: St. Francis Hospital and Medical Center, CT 1986-1987
Residency: St. Francis Hospital and Medical Center 1987-1989
Specialty: Family Practice

Peter J. Foley, M.D.
Shriner's Hospital
516 Carew Street
Springfield, MA 01104

Born: December 18, 1957
Medical: Medical College of Wisconsin 1991
Internship: Medical College of Wisconsin Affiliated Hospitals 1991-1992
Residency: Medical College of Wisconsin Affiliated Hospitals 1992-1995
Fellowship: Children's Hospital of Wisconsin 1995-1996
Specialty: Anesthesiology

Howard C. Lederman, M.D.
Healthsouth
14 Chestnut Place
Ludlow, MA 01056

Born: August 10, 1955
Medical: Robert Wood Johnson Medical School, New Jersey 1991
Internship: St. Peter's Medical Center, New Jersey 1991-1992
Residency: JFK/Johnson Rehabilitation Institute, New Jersey 1992-1995
Specialty: Physical Medicine/Rehabilitation

Philip Moraitis, M.D.
300 Stafford Street #212
Springfield, MA 01104

Born: April 29, 1960
Medical: Northwestern University Medical School, IL 1990
Internship: St. Joseph's Hospital, IL 1990-1991
Residency: University of Rochester Medical Center 1991-1994
Specialty: Ophthalmology

Marc A. Norris, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: June 11, 1963
Medical: Wright State University, Ohio 1990
Internship: Baystate Medical Center 1990-1991
Residency: Baystate Medical Center 1991-1995
Fellowship: Hartford Hospital/University of Connecticut 1995-1996 (Vascular Surgery)
Specialty: Vascular Surgery/General Surgery

Robert I. Park, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: December 19, 1965
Medical: Albany Medical College, NY 1992-1996
Internship: Baystate Medical Center 1996-1997
Specialty: Ophthalmology
Intern

Monica Popov, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: October 11, 1969
Medical: University of Alabama School of Medicine 1992-1996
Internship: Baystate Medical Center 1996-Present
Specialty: Obstetrics/Gynecology
Intern

Charles S. Weston, M.D.
904-916 Shaker Road
Longmeadow, MA 01106

Born: February 28, 1959
Medical: University of Massachusetts Medical School 1987-1991
Internship: Medical Center of Delaware 1991-1992
Residency: Medical Center of Delaware 1992-1995
Specialty: Internal Medicine/Pediatrics

David P. Wolfe, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: September 5, 1967
Medical: Georgetown University School of Medicine 1991-1995
Internship: Baystate Medical Center 1995-1996
Residency: Baystate Medical Center 1996-present
Specialty: Internal Medicine/Pediatrics
Resident

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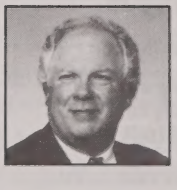

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In Memoriam

Dr. Lewis L. Huston, M.D., of Longmeadow, an orthopedic surgeon in the greater Springfield area for years, died December 31, 1996, at Harrington Memorial Hospital in Southbridge.

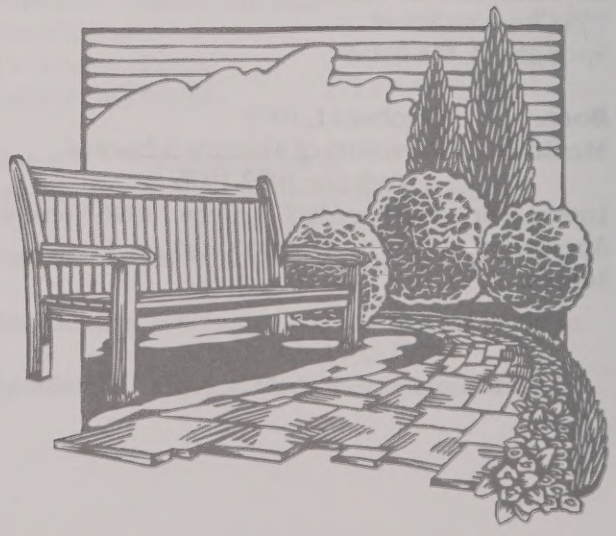
Besides practicing at the old Wesson and Springfield Hospitals, Mary Lane Hospital in Ware, and Wing Memorial Hospital in Palmer, Dr. Huston headed the outpatient department at Holyoke Hospital and the Skinner Clinic, and volunteered at the Shriners Hospital. He retired in 1979. He belonged to the Hampden District Medical Society, the Massachusetts and the American Medical Associations, and the American Orthopedic Association.

In the community, Dr. Huston was a 33rd degree Mason and was a past master of the Longmeadow Lodge as well as a deputy grand master of Masons in Massachusetts in 1970. He was a member of the Scottish and York Rite Bodies, the Royal Order of Scotland, and the Red Cross of Constantine. He attended the First Church of Christ for half a century.

Dr. Huston was reared in Centerville, Iowa, received his undergraduate education at the University of Iowa, and the M.D. from Harvard in 1934.

Dr. Huston is survived by his wife, the former Ruth Gillespie, and two grandchildren, Deborah and Robert L. Huston of Raleigh, NC. His son Lewis L. III, had died in 1992.

Contributions in Dr. Huston's memory may be made to the First Church of Christ at 763 Longmeadow St., Longmeadow, MA 01106, or the Shriners Hospital for Children, 516 Carew St., Springfield, MA 01104. ■



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In Memoriam

Dr. Lewis F. Pollak, M.D., of South Hadley, a vascular surgeon at Baystate Medical Center for many years, died there on December 31, 1996.

Dr. Pollak was born in New York City and went to Franklin and Marshall College. He received the M.D. from Downstate Medical Center in Brooklyn, N.Y., did his internship at Mary Hitchcock Hospital in Hanover, N.H., and his residency at Maine Medical Center, Portland.

He had lived in Springfield, Longmeadow, and South Hadley.

Dr. Pollak is survived by his wife, Karen Leslie Pollak; sons Adam Sydney Pollak of Northampton and Noah Benjamin Pollak of Boston; daughter Dara Beth Pollak of Longmeadow; stepson Michael Nichols of South Hadley; mother Clara Pollak Ulansky of New Rochelle, N.Y.; twin brother Dr. Edward Pollak of Exton, PA; brother Dr. Henry Pollak of Montrose, N.Y.; sister Ann Adelman of Riverdale, N.Y.; and several nephews and nieces.

His funeral was held in Mount Vernon, N.Y., with burial in Rochelle Park, N.J.

Memorial contributions may be made to Temple Emanu-El, 306 Rumsey Road., Yonkers, NY 10705, or to any charity. ■

In Memoriam

Dr. Maurice B. Ruben, M.D., formerly of Longmeadow, MA, died December 17, 1996 in Rockville, Maryland at the age of eighty-three.

Dr. Ruben practiced for many years in the city of Springfield as both a specialist in ophthalmology and otolaryngology.

Born and schooled in Boston, MA, he graduated from Boston University in 1935. He received his medical degree from Boston University School of Medicine in 1939. Dr. Ruben received his resident's training at both Worcester State Hospital and Boston City Hospital from 1940 through 1944.

He leaves his wife, Helen: a son, Robert A., and two daughters, Joyce D. and Leslie J. Cohen. ■

Short Notes

Friedmann Named to ACS Executive Committee

Dr. Paul Friedmann, Chairman of the Department of Surgery of Baystate Medical Center for 26 years, has been named by the Board of Governors of the American College of Surgeons to an initial 2-year term on its Executive Committee. The two year term may be extended.

The Board of Governors, composed of 400 individuals from all states, surgical, scientific, and academic groups, is responsible for communications between the Board of Regents and the members. The Executive Committee is a group of 6 governors charged with coordinating these communication activities and the activities of the other committees of the board. A Chair, Vice Chair, Secretary, and 3 members elected by the Board of Governors comprise the Executive Committee.

Besides his new appointment, Dr. Friedmann is the New England Surgical Society Representative to the Board of Governors of ACS, President-Elect of the Council of Medical Specialty Societies, and has served as Vice President for Academic Affairs for Baystate Health Systems since August, 1996.

Dr. Friedmann is a graduate of Harvard Medical School, did postgraduate training at Presbyterian-University of Pennsylvania Hospital in Philadelphia, and fellowships in surgical oncology at Roswell Park Memorial Institute in Buffalo and vascular surgery at the Texas Heart Institute in Houston. ■

Odds And Ends

WGBY/Channel 57 has started its own version of HDMS' "Housecalls," titled "Doctors on Call," and is interested in input from physicians. Jim Madigan is host and contact person at (413) 718-2801 ext. 268. Topics that will have been covered include multiple sclerosis, lupus, cystic fibrosis, epilepsy, asthma, menopause, and arthritis.

If you have suggestions for future shows and/or would be willing to appear, please call Jim Madigan. In WGBY's format, only two physicians appear and answer questions live as they are called in, with Mr. Madigan serving as M.C. ■

Hampden District Medical Society
1111 Elm Street
West Springfield, MA 01089
Tel.: 413/736-0661

NOTICE

A packet of information has been received from David J. Noonan, Esq. of Cohen, Rosenthal P.C. in regards to accessing medical records from the now closed Ludlow Hospital.

Should anyone need information please call the office and a copy of the instructions received from Attorney Noonan will be mailed to them.

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The Sisters of Providence Health System offers a continuum of care, from maternity services at the new Family Life Center at Mercy Hospital to quality home health services through Providence HomeCare. This seamless approach allows us to utilize all our system resources to deliver comprehensive, high quality care.

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